



Integrated Safeguards Data Sheet Identification / Concept Stage (ISDS)

Concept Stage | Date ISDS Prepared/Updated: 25-Feb-2019 | Report No: ISDSC23014



BASIC INFORMATION

A. Basic Project Data

Project ID	Project Name	Environmental Category	Country
P165052	Support to DRC human African trypanosomiasis control program	B - Partial Assessment (B)	Congo, Democratic Republic of
Team Leader(s)	Estimated Date of Approval	Managing Unit	Financing Instrument
Hadia Nazem Samaha, Karamath Djivede Sybille Adamon		GHN07	Investment Project Financing

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PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	0.00
Total Financing	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	2.75
Japan Social Development Fund	2.75

B. Project Development Objective(s)

The proposed project development objective (PDO) is to leverage recent developments in HAT treatment and other control tools to improve access to HAT health services for affected communities in ten health zones within five targeted provinces of the DRC. The five selected provinces are Kwilu (ex-Bandundu), Mai-Ndombe (ex-Bandundu), East Kasai, Lomami, and Tshopo, and the ten health zones proposed are Kwamouth, Mushie, Bolobo (part), Bandundu, Bagata, Masi Manimba (1), Moyen Kwilu (Djuma), Tshilenge, Cilomba, Ngandajika, Isangi, Yakusu, Yabaondo, and Opala. The ten health zones in the five targeted provinces have a combined estimated population of 1 million people, comprised of approximately 1072 villages. The estimated total target beneficiaries from these health zones is drawn from about 700 endemic villages, with an estimated population of 675,000, representing almost 70% of the total population within the ten health zones. The project aims to provide access to screening to 95% of the target population (641,000 people), estimating that 50% of them are women.

The PDO will be achieved by strengthening capacity at the peripheral health services level to detect and treat HAT



using rapid diagnostic tests and the current standard of care and support uptake of new treatments once available. It will also strengthen community engagement in HAT detection and management so that affected communities understand the risk of HAT, participate in case detection activities, and facilitate implementation of new treatments.

C. Project Description

The project is designed to overcome key capacity gaps for HAT case detection and case management, in 10 health zones from Kwilu (ex-Bandundu), Mai-Ndombe (ex-Bandundu), East Kasai, Lomami, and Tshopo provinces of DRC where HAT is endemic and DNDi is the main partner of the national control program for control and surveillance of HAT, so as to improve targeted communities access to those services. These efforts should contribute to disease diagnosis and elimination, but treatment will be funded from other funding sources.

Through Component 1, the project will strengthen capacity of the peripheral health system to deliver HAT services at the community level. It will reach remote communities that have not, to date, been effectively targeted to provide diagnosis as close as possible to where patients live, thereby contributing to reduce disease prevalence. Through Component 2, the project will strengthen community engagement in HAT surveillance and control, by using interventions such as information, education, and communication techniques.

The project is innovative as it will contribute to:

- Building new capacities among public services at the health zone level and reaching new beneficiaries who were not covered by existing programs and by building capacity for HAT services delivery into the mainstream health system at the peripheral level.
- Building new capacities among beneficiary groups by building knowledge around HAT and fostering demand generation for HAT-related services
- Bringing alternative ways of delivering services, more effectively and/or efficiently, to beneficiary populations, including fostering awareness of and extensive access to new oral treatments once approved but treatment will not be funded from the JSDF Project.

The project will also document experiences and results to inform future community-level interventions.

The proposed Project will finance the following three components:

Component 1: Strengthen capacity of the health system to deliver HAT services at the community level (USD 1.562 M) through screening and diagnosis but not treatment.

Subcomponent 1.1: Scale up capacity for active and passive case detection at the community level (USD 1.398 M)

Active screening: The project will support implementation of the Card Agglutination Test for Trypanosomiasis (CATT), or RDTs (Rapid Diagnostic Tests) both serological screening tests that allow for mass screening at the community level. Mobile teams are composed of community health workers (seven to



nine people) for CATT complemented with mini-mobile teams (two technicians going door-to-door and screening people) for RDTs and both detect seropositive suspects that are later tested with a confirmatory parasitological test. Both CATTs and RDTs have been tested and deployed successfully in DRC. CATT and RDTs increase the performance of the final parasitological diagnosis by targeting only seropositive individuals, thus reducing the total numbers to be examined by microscopy. DNDi currently supports 10 mobile teams who perform active case detection.

The project will supply these teams with 200,000 CATT tests per year for screening (about one third of total need). This grant will also support the purchase of 10 motorbikes to facilitate transportation to remote areas for members of the mobile teams performing screening activities with RDTs in difficult to access areas and in non-permanent settlements in endemic areas that cannot be reached by car. At present, teams can go to villages but cannot access hard-to-reach 'encampments' where mini-mobile teams are needed due to high risk of transmission. This complements, but does not duplicate, existing support from the BMGF for cars and boats for the mobile teams.

There is also a need to strengthen passive case detection and diagnosis at the peripheral health facility level. In known areas of endemicity, the capacity of peripheral health centers should be strengthened/developed for local detection of cases. Even if in some cases these structures exist and are well-identified, they often lack the tools and trained staff to deliver on this objective. This capacity strengthening activity will focus on those identified community health centers and provide them with the tools and training to identify, among people self-presenting for health services, individuals with signs and symptoms suggestive of HAT, screen, and diagnose them and, if confirmed, recommend treatment with the most effective treatment available. However, treatment will not be funded from the JSDF grant resources. This will include upgrading of equipment and supplies (10 microscopes, other equipment as needed, 20,000 rapid screening tests per year, and additional lab consumables packages (e.g. disposable gloves, syringes, etc.) for 20 health centers for screening and diagnosis), training of health care personnel at the community level to use diagnostic tools, installing solar energy systems in 10 facilities given limited access to electricity in those areas, as well as additional rehabilitation and maintenance of selected community health centers and posts (5 health centers and 5 health posts per year over three years). It will ensure that the selected health facilities can provide adequate care [but treatment would not be funded from the JSDF Project] to all identified HAT patients in their community. Care will be taken in the selection of facilities to be supported through this grant to avoid any overlap with support from other donors also contributing to these activities. Selection will be finalized by appraisal.

Subcomponent 1.2.: Build capacity of the health system for the introduction of new treatments at the community level (USD 0.164 M)

While the JSDF will not finance activities related to treatment, it is worth mentioning that the first oral treatment for HAT (fexinidazole), developed by DNDi and partners are specifically designed to be adapted for use in the remote settings in which HAT is found in DRC, is anticipated to be approved and introduced into the DRC health system by the end of 2018 or the beginning of 2019. This will create a paradigm change in how HAT is treated as this is the first time that patients can be directly involved in HAT treatment in contrast



to the past where the treatment could never be self-administered. It will require a parallel update in guidelines for patient care and treatment at the national level. While JSDF funds will not be used to implement the introduction of new oral treatment, that needs to be supported by other donors rather than via the JSDF which cannot finance treatment. This activity will support the development and introduction of new treatment guidelines via district health teams, development of training materials and training of health zone authorities and staff on new treatment protocols (one training organized per year in each province up to a total of 15 sessions) to ensure that once new treatments are made available through the health system, they are also used appropriately. This is a fully new activity unsupported by any existing donor.

Component 2: Strengthen community engagement in HAT surveillance and control towards elimination. (USD 0.910 M)

The mobile teams are the cornerstone of the active case detection strategy in DRC. However, some individuals screened by the mobile teams may not be detected at the time of the screening for any number of reasons. Therefore, educating targeted communities and engaging them as active participants to identify signs and symptoms of HAT and refer the suspected persons for HAT case detection and case management, are critical to ensure progress. Through this component, an effective approach will be devised to engage the community in surveillance and control activities on an ongoing basis and make them part of the continuum of the HAT control system.

Subcomponent 2.1: Assessment of Community Knowledge and Behavior related to HAT Prevention, Diagnosis and Treatment (USD 0.222 M)

Community assessment has not been done systematically in DRC, although several studies have reported on the main beliefs and community reactions to previous treatments, mainly on the barriers to acceptance of participation in mobile activities when melarsoprol was the main (and very toxic) treatment for the second stage of the disease. Past studies, in that context, have found that sociocultural factors can be important barriers to screening and treatment seeking behavior.[1]

This sub-component will provide support for a baseline social behavioral assessment to be conducted in the five targeted regions to better understand the current sociocultural barriers to health seeking behavior (including gender-specific behavior), knowledge of HAT infection and treatment options, and determine appropriate interventions, to be funded from other sources, that are also gender-informed to address them. This baseline assessment expects to use key informant interviews and focus group discussions rather than a survey methodology, not only to ensure timely availability of the results and information to guide future activities but also to ensure active participation of the targeted beneficiary communities/groups. The baseline assessment will be conducted by a consultant(s) with experience in the health sector and expertise in community engagement and behavior change communication, supported by local health care workers to maintain the link for future health care services, and will ensure that representatives of different community groups are met separately, as necessary, to ensure transparency, comfort, and ownership by the community.

The choice of communities to assess will be based on existing information, available at the PNLTHA, from the past mobile teams' activities, including participation data in each target area, as well as the detected



prevalence (number of cases in the selected villages in the three previous years). This quantitative information will be complemented with the qualitative analysis about the perception of the disease and the present understanding of the available treatment solutions, but actual treatment will be funded from other sources. It will examine specific vulnerable groups, including women and children. Detailed baseline and endline studies are under the M&E Section.

[1] *Should I Get Screened for Sleeping Sickness? A Qualitative Study in Kasai Province, Democratic Republic of Congo*, Alain Mpanya, David Hendrickx et al., Jan. 2012 available at <http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0001467>

Baseline and Endline Studies:

The baseline assessment will inform the design of specific interventions that might include activities at the community level such as: workshops and demonstration events related to information and education campaigns (IEC); community activities targeting beliefs and harmful social norms that contribute towards greater HAT exposure or delay treatment thus increasing the risk of transmission and delaying disease elimination; psychosocial support for affected patients, etc. The baseline assessment will also inform what type of accompanying behavioral interventions or messaging would best support the introduction of the new HAT treatments to be funded from other sources.

At the end of the grant period, a post-intervention social behavioral assessment will be performed in the targeted endemic communities, again considering specific feedback from different vulnerable groups to evaluate changes in perception and behavior. Success shall be positive changes in behavior and perception about HAT prevention, diagnosis and treatment and utilization of local health services which would contribute to a steep reduction or even absence of new cases in the targeted communities. A specific assessment tool will be designed to measure this impact.

The sub-component will provide support for a consultant(s) with the appropriate qualifications (monitoring and evaluation, social science, community engagement and behavior change communication) and with experience in conducting similar assessments in the health sector. The detailed request for proposals will outline the minimum specifications of coverage for focus groups and interviews within the provinces to ensure that there are sufficient inputs from the intended beneficiaries.

The baseline and post-intervention assessment results will be shared with the PNLTHA and partners involved in DRC HAT control activities and integrated into the training provided under sub-component 2.2 as outlined below.

Subcomponent 2.2: Support community participation in HAT case detection, monitoring and surveillance (USD 0.688 M)



As part of building the local capacity, the project will support interventions to encourage greater community participation to identify and self-refer suspect cases to community health centers in between visits from the mobile teams, hence fostering community-level case detection, monitoring and surveillance so that affected patients can be detected early and cared for effectively. These interventions will be targeted towards increasing community use of local health services by improving knowledge and reducing practices and harmful behaviors at the community level that limit health seeking behavior and result in increased HAT vulnerability.

The interventions will be designed based on results of the social behavioral assessment in sub-component 2.1, taking into consideration all the inputs from the communities as well as local health personnel engaged in the process, and then implemented with the support of the NSSCP/PNLTHA, provincial, district, and local health authorities as well as community key opinion leaders (KOLs), such as chiefs, traditional healers, village elders, or women at the community level. IEC campaigns and messaging would be appropriately targeted at the local and health facility level, through community radio stations or similar locally accessible means.

A training cascade approach will be used to train provincial and district staff as trainers of trainers (TOT), which will then train the health zone personnel. Trained local health officers would then engage with and train community KOLs, who would then be equipped to provide guidance to their specific community groups. In addition, the mobile teams will also play an important role of engaging community KOLs, including special outreach activities to traditional healers. Traditional healers play a very important role in these communities as most patients first go to traditional healers, which can delay diagnosis and access to treatment, so close coordination and collaboration with this dimension will be critical.

The KOLs will act in conjunction with local health officers to provide communities with correct health information regarding HAT, the most up to date treatment and training on the clinical symptoms of HAT, thereby contributing to improving case detection and reducing the stigma associated with the disease. As necessary, particularly at the local/community level, the TOT training may necessitate some gender disaggregated training to allow appropriate cultural and social norms to be followed to improve the acceptability of the training and messaging. The sub-component will also provide support for materials required for the IEC campaign and tools and documents needed for trainings.

The sub-component will provide support for the two community-based learning specialists who will conduct one national level training of trainers (TOT) session with the support of the baseline assessment consultant(s) for provincial level health personnel. Then the trained provincial TOTs would conduct two training sessions with their relevant district and local health personnel. District- and local-level health personnel would then train KOLs in their health zones so that the KOLs are able to also share that information accurately within their communities. KOLs trained in these sessions would be expected to disseminate the information shared within their communities through their own community activities. It is expected that there would be at least three KOL training sessions in each of the targeted provinces and then the KOLs would subsequently be involved in multiple activities/events to disseminate the information to



their communities and ensure greater distribution of the information. Combined, there should be one national TOT session, two sessions in each province (total 10), and 30 sequences at the health zone or KOL level after the end of the assessment.

Training of trainers (TOT)

- Place: Kinshasa
- Trainers: Project Coordinator; baseline assessment consultants (two); two Community-based Learning Specialists
- Trainees: Four (4) Provincial HAT Coordinators and four (4) Supervisors (East Kasai and Lomami are covered by one coordinator); Five (5) Persons from Provincial Direction of Health in charge of community-based activities (Provincial supervisor); 10 district supervisors from involved health zones
- Duration: Three (3) days

Training health staff (facilitators)

- Place: Each provincial capital except Lomami, as they will join at Mbuji Mayi
- Trainers: One National baseline consultant; one Community-Based Learning Specialists; one Provincial HAT Supervisor; one Provincial Supervisor; one District Supervisor per health zone
- Trainees: Up to 30 (including staff from the peripheral health structures and community mobilizers from the health teams) that will be identified during the assessment per province.
- Duration: Two (2) days

Training Key opinion leaders (KOLs) at health zone level

- Place: At each health zone headquarters
- Trainers: One community-based learning specialist; one district supervisor; one or two community mobilizer(s) from the directly involved mobile teams
- Trainees: Up to 30 KOLs from the villages of a given health zone
- Duration: Two days

Community-level interventions facilitated by the KOLs will be continuous starting the second year of the project. They will not be formally programmed as they would be “opportunistic” to take advantage of other community-based events, engagements and activities and the availability of mobile teams and health zone officials. These interventions incorporate the use of locally available media both for dissemination and information purposes. The specific examples of these interventions will be more clearly defined based on the baseline social behavioral assessment.

- Place: At each village center at least two activities per community per health zone. Overall, it is expected that there shall be over 600 community-level activities over the three years.
- Trainers: One community-based learning specialist and/or one district supervisor and/or one community mobilizer from the directly involved mobile teams if the team is in their scheduled route



at the village or nearby. Ideally, there should be at least five KOL per event, one to two of them trained under the program.

- Trainees: All villagers that show up; water to be provided
- Duration: Two to three hours
- Content: Community meetings; theatre; sport events; side training during HAT active case search or other health system activities (vaccination campaigns...)

At the community level there will also be home based visits and case search, and specific support for patient referral to diagnostics and treatment centers.

Component 3: Project Management and Administration, Monitoring and Evaluation, and Knowledge Dissemination. (USD 0.277 M)

Subcomponent 3.1: Project Management and Administration (PMA) (USD 0.207 M)

This component will finance the provision of goods, consultant services, training, and operating costs to support project monitoring, evaluation, and management, with an aim to ensure efficient, effective, transparent, and accountable delivery of this project. The project implementation unit (PIU) will be the DNDi office in Kinshasa and will be composed primarily of DNDi staff, with capabilities added through hiring of consultants, as needed. The project will be overseen by an overall project coordinator (international DNDi staff) together with the Kinshasa Head of Office (country-level coordination and supervision). The Grant financial management (FM) and procurement functions will be ensured respectively by DNDi's FM staff and Logistics Officer, which is responsible for procurement, and supported by a Procurement Specialist (to be added if necessary). Final project management arrangements, together with any additional fiduciary capacity needs, will be confirmed during Appraisal.

The project will also finance the mandatory external audits (for each of the four expected years of the project life cycle), Project Launch, Mid-Term Review and closing activities, and the Implementation Completion Report (ICR).

Subcomponent 3.2: Monitoring and Evaluation (USD 0.070 M)

The monitoring and evaluation of final outcomes and results under component 1 are embedded within the component activities, while the endline assessment as well health screening data will provide outcomes and results for component 2. These qualitative and quantitative outcomes together with the medical results achieved during implementation will be combined in the final report by the Implementing Agency to provide an overall picture of the impact of the project. Therefore, there will be no impact evaluation necessary to be conducted. M&E arrangements will include participatory monitoring of the activities by the beneficiaries through regular consultations on project implementation. Beneficiary inputs will be collected routinely through KOL interviews during field visits by the project trained personnel, to gain the views of intended beneficiaries regarding the impact of the project interventions.



DNDi has existing M&E staff for collecting and reviewing data related to the grant outcomes that have been the main focus of their current activities and can easily support the collection of necessary data for activities under Component 1. These staff will be supplemented by the recruitment of an additional M&E specialist, who would be responsible for coordinating component 2 activities, reviewing and enhancing the participatory monitoring data (design a beneficiary survey and work with mobile teams to administer it), and collecting and analyzing data for the overall project results framework.

Subcomponent 3.3: Knowledge Dissemination (USD 0.000 M - covered by existing DNDi budget)

The project will develop good practice notes on community engagement in disease surveillance and control (directly related to this project) and introduction of new treatment mechanisms at the community level and the associated risks with this introduction but not actual administration of the drugs which cannot be funded from the JSDF funds. These will inform policy discussion and scale up of interventions that effectively engage communities in low-resource settings through World Bank or other support. Results and experiences will be disseminated through the HAT Platform newsletters, scientific conferences, and publications in peer-reviewed journals. A specific mass media communication strategy (at national and international level) will also be developed, including visits to the field. Knowledge dissemination will be managed through the vehicle of the existing HAT platform (by its coordinator) and DNDi staff. These costs will not be covered by the JSDF grant as they are part of ongoing DNDi project activities and adequately supported at present. However, activities related to treatment would not be funded from the project activities.

The experience of community intervention to strengthen capacity for disease surveillance through screening and diagnoses of disease will be shared internally at DNDi and adapted to other disease programs and contexts (Leishmaniasis, Chagas, Onchocerciasis, Mycetoma, Pediatric HIV, and Hepatitis C teams, working in other countries in Africa, Latin America, and Asia) within the regular R&D monthly meetings. Within the HAT team, a parallel intervention is being planned at the community level in Uganda and Malawi in the context of the extension of new treatments to the *T.b. rhodesiense* endemic areas.

One HAT Platform newsletter per year will include updated information about the project evolution and further presentations on specific information (baseline, project implementation evolution, challenges, and solutions found) will take place annually alternating scientific meetings as the HAT Platform-EANETT (East African Network for Tsetse and Trypanosomosis) and the ISCTRC (International Scientific Council for Trypanosomiasis Research and Control) conferences organized by the African Union in alternate years. HAT Platform-EANETT in 2018 and 2020 and ISCTRC in 2019. The Partners of the NSSCP/PNLTHA, including WHO, FIND, IRD and IMT, usually meet twice a year to share experiences and clarify the destination of their financial support within the programmed activities. They support different mobile case detection teams, but always keeping the same terms and conditions as established by the PNLTHA to avoid differences among staff in payments or equipment. These meetings will certainly be relevant to discuss content and adapt strategies regarding other partners' input and results.

The first component of this project will be implemented over 3 years, and the second component will start the first year with the assessment and the second year with training and implementation. End-line report will



be prepared at the beginning of the fourth year. The full project through the Closing date will allow for 4 years to accommodate for feedback to the local authorities and communities, delays in implementation and possible lags in activities and avoid transaction costs to extend the closing deadline.

SAFEGUARDS

D. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project will be implemented in 5 provinces (Kwilu, Mai-Ndombe, East Kasai, Lomami, and Tshopo). No civil works will be undertaken and no adverse environmental or social impacts are expected. The project does not require any land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihood. The project is expected to have a positive impact for all beneficiaries including vulnerable groups such as children, women, and the poor. World Bank Grievance Redress Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org

E. Borrower's Institutional Capacity for Safeguard Policies

At the national level, DRC has legislative and regulatory frameworks which are conducive to good environmental management. In addition, they have signed a number of international treaties and conventions to ensure good environmental governance. The Government of DRC has experience with the Bank's Safeguard Policies due to Bank-funded projects across different sectors. However, implementation capacity is weak. The Ministry of Environment, Conservation and Sustainable Development (MECNDD) governs environmental policies and their compliance. The MECNDD's main department in charge of environmental monitoring and management is the National Agency for the Environment (Agence Congolaise de l'Environnement - ACE). The ACE is responsible for safeguards compliance of all projects in the country and is familiar with safeguards instruments such as the Environmental and Social Management Framework (ESMF), the Resettlement Policy Framework (RPF), and the Indigenous Peoples Policy Framework (IPPF). The agency (ACE) has limited capacity, and still largely relies on donor and project funds to carry out its field supervision duties. At the provincial level, government agencies often do not have the equipment, trained



staff, and management capacity necessary to monitor social and environmental impacts. Citizen engagement is often poor at the national level, despite decentralization efforts, resulting in limited ownership. The Bank has had a participatory approach through its various investments, and civil society (vocal and active), local institutions, and leaders are invited to meetings during the design of projects. At project level, the beneficiary will prepare necessary instruments and implement mitigation measures related to the triggered safeguards policies, including special care for adequate medical waste disposal. The environmental and social safeguards instruments have already been prepared under the ongoing Health Systems Strengthening project (P147555) and will be adapted as needed to address specificities of this project. Overall, safeguards management is challenging in the environment of DRC. To address the issues at the national level, the World Bank is engaging in an Advisory Services and Analytics (ASA) on existing Environmental and Social national framework and institutional capacity, which will allow the Bank to better address and mitigate risks and impacts of investments (project launched in October 2017).

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F. Environmental and Social Safeguards Specialists on the Team

- Grace Muhimpundu, Social Specialist
- Richard Everett, Social Specialist
- Joelle Nkombela Mukungu, Environmental Specialist

G. Policies that might apply

Safeguard Policies Triggered by the Project	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The environmental impacts of the project are expected to be minimal. Anticipated environmental safeguard issues related to project activities include management of liquid/solid waste (including hazardous waste) generated from diagnosis and treatment of affected patients, and overall laboratory safety aspects. These issues are limited to the specific health facilities supported which are required to comply with applicable regulatory requirements of the government of DRC (on biomedical waste management, hazardous waste management, Water Act, and so on) and international GCP. The instruments will be updated (Environmental and Social Management Framework as well as a Biomedical Waste Management Plan) and disclosed prior to appraisal.
Natural Habitats OP/BP 4.04	No	This OP is not triggered, as there will be no



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		potential impact on natural habitats.
Forests OP/BP 4.36	No	The proposed project will not affect forests, nor will it involve de/re-forestation.
Pest Management OP 4.09	No	No use of pesticides or health-related concerns with respect to vector management are expected.
Physical Cultural Resources OP/BP 4.11	No	The project does not trigger this policy as no excavation or dredging will take place.
Indigenous Peoples OP/BP 4.10	No	Indigenous Peoples are not found in the zones of intervention.
Involuntary Resettlement OP/BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihoods.
Safety of Dams OP/BP 4.37	No	The Project will not finance any dam construction or rehabilitation.
Projects on International Waterways OP/BP 7.50	No	None of the intervention sites concern International Waterways.
Projects in Disputed Areas OP/BP 7.60	No	None of the intervention sites are in disputed areas.

H. Safeguard Preparation Plan

Appraisal stage ISDS required? Yes

a) Tentative target date for disclosing the appraisal stage ISDS

01-Mar-2019

b) Time frame for launching and completing the safeguard-related studies that may be needed.

An Environmental and Social management Framework (ESMF) and Medical Waste Management Plan (MWMP) have already been prepared and disclosed for the ongoing Health Systems Strengthening project. This project will adopt and conform to these existing safeguard instruments. These environmental and social documents will be adapted/complemented as needed to reflect specificities of this project.

APPROVALS

Team Leader(s):	Hadia Nazem Samaha
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Approved By

Safeguards Advisor:	Maman-Sani Issa	01-Feb-2019
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Practice Manager/Manager:	Trina S. Haque	01-Feb-2019
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¹ Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) by the Bank and (ii) in country by the Borrower/Recipient, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.

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